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ABSTRACT

The Better Babies Project is attempting to intervene with inner city pregnant women, many of whom are poor, to change their behavior in order to reduce the many behavioral risks associated with delivering a low birthweight infant. The research objective of this intervention is to offer and document the provision of consistent and comprehensive services to pregnant women with differing risk factors and differing needs. Several concepts underlie this intervention approach. They include: (1) one-on-one delivery by paraprofessionals to participants; (2) the provision of a comprehensive set of services; and (3) monthly development and reassessment of needs-based intervention plans. Some of the tools which were developed to manage a pregnancy intervention fall into three categories: (1) standardized assessment inventories and records of needs and services; (2) an administrative data base that records needs and services; and (3) interim measures of success in applying the intervention. Included are sample handouts and forms used in the intervention and preliminary data tables. (RJC)

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CHANGING MATERNAL BEHAVIOR

IN AN URBAN LOW BIRTHWEIGHT INTERVENTION[1]

Deborah L. Coates, Ph.D.
Project Director

The Better Babies Project

Changing human behavior can be greatly facilitated by the use of diverse, supportive, and structured systems and tools. My remarks this morning will focus on how we at Better Babies are attempting to achieve change. I will describe our model and some of the tools and systems we use to encourage and support this behavior change in pregnant women in Washington, D.C.

The Better Babies Project is attempting to intervene with individual pregnant women, many of whom are poor, and all of whom live in an inner-city community, to change their behavior so that they reduce the many behavioral risks associated with delivering a low birthweight infant. Low birthweight and associated infant mortality and morbidity are significantly related to various life-style choices that pregnant women make (Coates, 1988; Institute of Medicine, 1985). Our objective in this research intervention is to offer and document the provision of consistent and comprehensive services to pregnant women with differing risk factors and thus differing needs. These

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chosen to seek these objectives within the context of a free standing community center staffed by paraprofessionals working under the direction of a community health nurse and a professional social worker.

We believe it is important to have a range of management systems in place if a longitudinal, multifactor intervention is to be effective. Human behavior, particularly lifestyle behavior, is complex and firmly established for most women by the time they become pregnant. A community project that is broad-based and attempting to serve an entire community, as we are, comes in contact with women of many differing levels and intensities of behavioral and medical risks. Staff need help to be maximally effective in addressing these diverse risks.

Management tools are important to us also because we are using paraprofessionals teamed with a nurse or social worker to offer complex health education and social support. Paraprofessional workers have many advantages but require detailed management tools to help ensure accurate application of the intervention across women of varying needs. Our management tools also help service providers balance the need to remain objective and collect data and the need to offer high quality supportive human services.

Key Concepts Underlying the Intervention

Several key concepts underlie our intervention approach. I will first describe them briefly and then describe some of the tools we have developed to manage this intervention.

to Participants

s in Better Babies receive needs based

staff in a one-on-one relationship"),

the major concepts used in our approach:

1. Pregnant women who enroll in Better Babies are called Participants. Each pregnant woman participates with us in developing and implementing a service plan for her individual situation and in evaluating its outcome. Our approach uses a membership social work perspective (Falck, 1988). We recognize that each woman who joins Better Babies is a member of several groups -- family, ethnic, socioeconomic, friendship, cultural, and personality type. We try to capitalize on her experiences in being a member of these groups by encouraging her to participate with us in working toward social change. We invite her to become a member of our group and to work with us while recognizing her social involvement with other groups.

2. Staff who deliver the majority of direct services are paraprofessionals -- known as Service Coordinators. They are community, age and experiential peers of our participants. These paraprofessionals work to establish a pathway into a new group for a participating woman. They work closely with the woman and with a professionally trained community health supervisor to develop and implement a reasonable, individualized health plan.

3. Services are provided within the context of a one-on-one, socially supportive relationship where the paraprofessional Service Coordinator acts as an advocate or big sister to empower each Participant to change her behavior.

A Comprehensive Set of Services Is Available

The second slide ("A wide array of risk-reduction services are offered to meet a variety of individual needs"), represents another important concept underlying our work. We use a comprehensive intervention approach. We have identified all major life-style risks currently associated with low birthweight that can potentially be changed during pregnancy and have developed detailed interventions that attempt to facilitate change in each identified area. When a woman enrolls, we assess what specific risks she presents and help her when necessary to (starting at the 12:00 o'clock position on the figure and moving clockwise): gain weight, stop smoking, stop drinking, learn about low birthweight risks, get to prenatal care, find housing, stop drug use, get friendly support, use prenatal care, and obtain social services. To address such a complex set of developmental risk factors that affect a large number of women differently, we must be prepared to provide a wide array of interventions that address each of these risk factors.

In helping about 350 women each year to follow this positive health regimen, our service staff of 8 paraprofessionals and 2 professionals offers one-on-one counselling and support, health education, social service linkage, use of a drop-in center, transportation assistance, small cash incentives, and home visits.

Needs-Based Intervention Plans are Developed and Reassessed at Least Monthly

We assume that each women's needs are different and that detailed assessments are necessary for the staff to identify those needs and develop appropriate risk-reduction plans. As shown in the third slide ("Services are

provided according to needs; participants and staff reassess needs each month"), we assess risks at enrollment and reassess needs every four weeks, using one-on-one participatory sessions with women and detailed, standardized assessments to develop needs-based service plans. Health risks and other needs change over time. These changes must be incorporated into a service plan on an ongoing basis.

Service plans, as shown in the next slide ("The type and amount of services are tailored to meet a participant's changing needs over time"), are individualized. Each month's plan must begin with an evaluation of the effectiveness of the previous month's plan as well as an understanding of recent changes in the individual woman's situation. This information must be used to shape the plan for the current month. Each plan must address a woman's current needs and current circumstances. Thus in the example shown on this slide, you see that when this Participant enrolled we determined her most urgent need was to reduce smoking. Her second most urgent need was to stay linked to prenatal health care. Her third need was to receive some friendly support. By the time of the first reassessment she had stopped smoking, so our focus in that area shifted to helping her stay smoke-free. However, she had developed some medical problems, so it was urgent that we help her obtain appropriate help. We continued friendly support and initiated some health education on the warning signs and symptoms of preterm labor. At the second reassessment her medical situation had been resolved, so we continued encouraging her to remain smoke-free and increased our emphasis on health education.

This concept of individualized services is described further in the final slide ("Individual services vary person to person and month to month, based on needs"). Each individual enters the intervention presenting a different risk profile. Each woman's needs continue to differ in content and intensity over time.

Thus at any one time we have several hundred different multi-factorial risk-reduction plans in operation - a major challenge for both supervisors and paraprofessional staff.

Some Tools Developed to Manage a Pregnancy Intervention

The complexities of service delivery under these conditions require the use of a number of management tools, systems and concepts in order to ensure effective implementation of the intervention. How do we manage to offer different services to a variety of women and to support the paraprofessional and professional staff who must both provide these services and collect intensive and detailed longitudinal data?

Let me describe some of the tools we use. They fall into three categories: 1) standardized assessment inventories and records of needs and services; 2) an administrative data base that records needs and services; 3) interim measures of success in applying the intervention. Together, these tools help us offer consistent, high-quality, needs-based services to large numbers of women with diverse needs.

Standardized Inventories and Records

Twelve standardized data collection instruments help our paraprofessional staff offer consistent high-quality services and to help our managers monitor

that service. These instruments were developed during an 18-month pilot trial, during which the service delivery staff suggested numerous modifications and improvements based on service needs and field experience. Hence the staff find them easy to use and effective.

Two of the instruments we use to document service delivery are the Records of Needs and Plans (RNP) and the Activity Form. A copy of each is in the handout. Let us first look at the Records of Needs and Plans. The RNP is designed like a Lotus spreadsheet. Various needs and risks are listed in the column on the left-hand side of the form. The next column -- "Original Plan" -- lets the staff team record which risks and needs they have decided they will encourage the Participant to attempt to change. They record these decisions by checking the appropriate boxes under the "Needs? No/Yes" columns. The plans are updated each month. Hence when these needs change, when new needs develop, and when needs are resolved, all this can be indicated in the remaining columns. This form allows the paraprofessionals to more easily implement specific risk reduction efforts and the professionals to more easily monitor service plans. A lengthy standardized interview, conducted monthly, forms the basis of each service plan.

A second instrument that helps to manage service delivery is the Activity Form. Again, a copy is included in your handout. This form is similar to a participant observation checklist. It provides a snapshot view of most services received by each participant in our intervention. Using the RNP and this Activity Form, a staff member can quickly assess specific identified risks, what risk-reduction services have been provided, when they were provided, and by whom they were provided. This is particularly helpful to the

staff as our intervention requires that we respond to participants on a drop-in or as-needed basis. If a Service Coordinator who has been linked in a one-on-one relationship with a woman is not available when a Participant needs assistance, these instruments help another staff member to quickly assess and respond to the woman's particular situation.

These instruments will also provide some useful and relatively unusual data for our intervention as they will allow us to quantify identified needs and what services were delivered in an attempted to meet those needs.

An Administrative Data Base: Service Monitoring and Data Editing

Using DATABASE IIIplus we have designed a customized database and a series of reports that allow us to monitor the needs of and service to each staff member's entire caseload in much the same way that the RNP and the Activity Form monitor this for individual women. These reports tell each paraprofessional Service Coordinator, for her caseload, and each professional supervisor, for the cases she is monitoring, a number of things, including: (1) contact information for pregnant women she has met but not yet enrolled in the program (that is, contacts' names, addresses, and phone numbers); (2) enrolled women who are at risk according to specific risk factors; (3) enrolled women who have not yet attended a prescribed number of LBW health education sessions; and (4) dates when monthly updates are to be scheduled for each woman in the caseload. These and other reports help paraprofessionals and their supervising professionals adhere to our complex protocol. This administrative data base also helps us edit our research database. When errors in the data are detected during input to the administrative data base,

corrections can often be made while service to the individual Participant is still in progress.

Interim Measures of Success

We also use several interim measures of success to monitor how well a particular intervention is being applied. These interim measures compare risk profiles for our participants to national and local nonparticipating samples. They also report participation rates for various risk reduction interventions and examine participant satisfaction with various aspects of the program. I will now share four examples of these interim measures of success.

One of our objectives is to enroll a large percentage of women giving birth in our neighborhood early in their pregnancies. Each month we monitor how many women we reach, how many we enroll, how many we are not able to enroll, and why. Table 1 shows (for two years of the program) women contacted, women enrolled, and the reasons why all women contacted but not enrolled were not enrolled. As you see, we did not lose significant proportions of women because they did not wish to enroll or because we identified them too late in their pregnancy but rather because they were ineligible because they lived outside of our service neighborhood.

We also monitor how many days elapse from when we first meet a woman until we enroll her. As shown in Table 2 in the handout, we are fairly efficient in this regard. Sixty-seven percent of our women are enrolled within a week after their first contact with the program.

Table 3 shows that enrolled women initiate prenatal care relatively early in their pregnancies. About half are enrolled between 11 and 16 weeks gestation and almost 70 percent are enrolled by 20 weeks gestation.

As a final example, Table 4 shows that we are reaching significant numbers of women with major risk behavior profiles. About 1/3 of our participants have smoked, another third used street drugs and another third used alcohol. We generate these interim reports monthly, quarterly and yearly.

Summary

The complex nature of health-related life-style behavior and the associated complex interventions necessary to attempt to change these behaviors require robust management strategies. We have therefore developed several management tools that promote adherence to our intervention and research design. We hope that these management strategies will help us to achieve our major outcome goal -- a reduction in the rate of low birthweight for the neighborhood we serve. We hope to share those results with you in the future.

References

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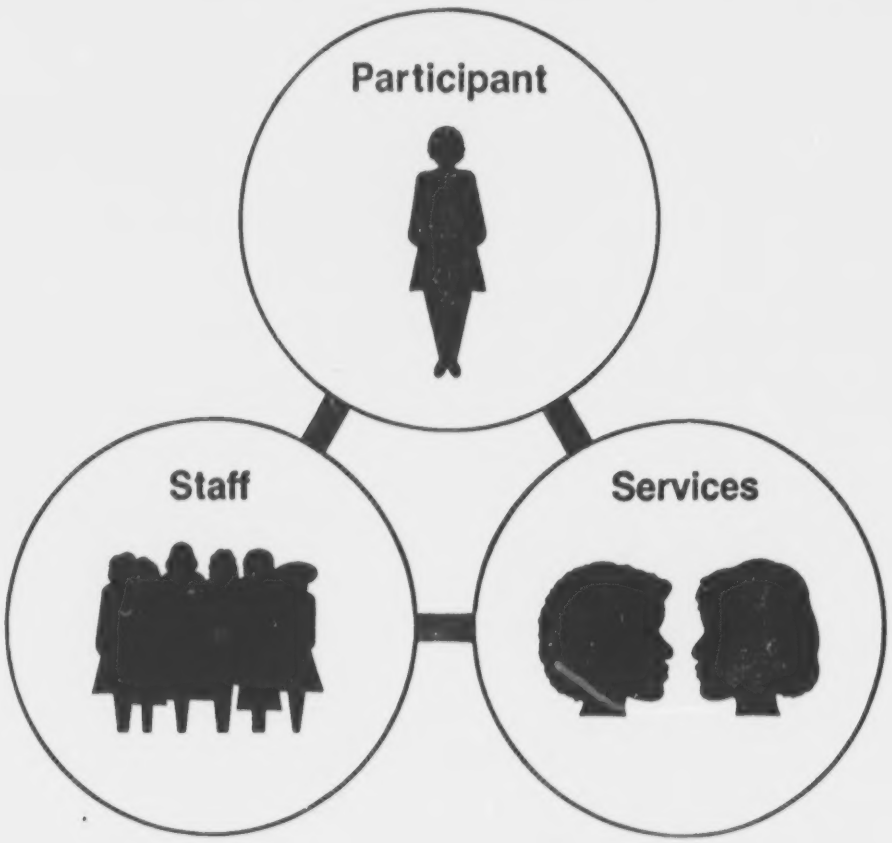
Institute of Medicine (1985). Preventing low birthweight. Washington, D.C.: National Academy of Sciences Press.

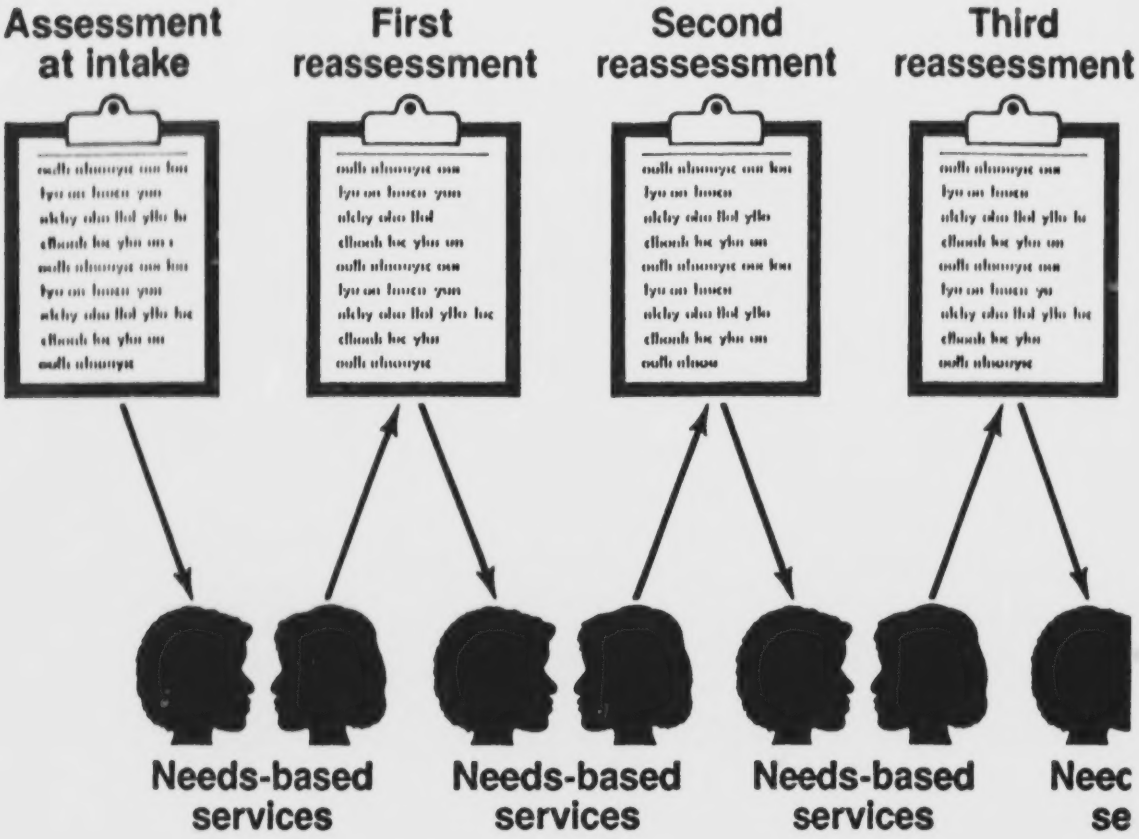
Participants in Better Babies receive needs-based services from trained paraprofessional staff in a one-to-one relationship.



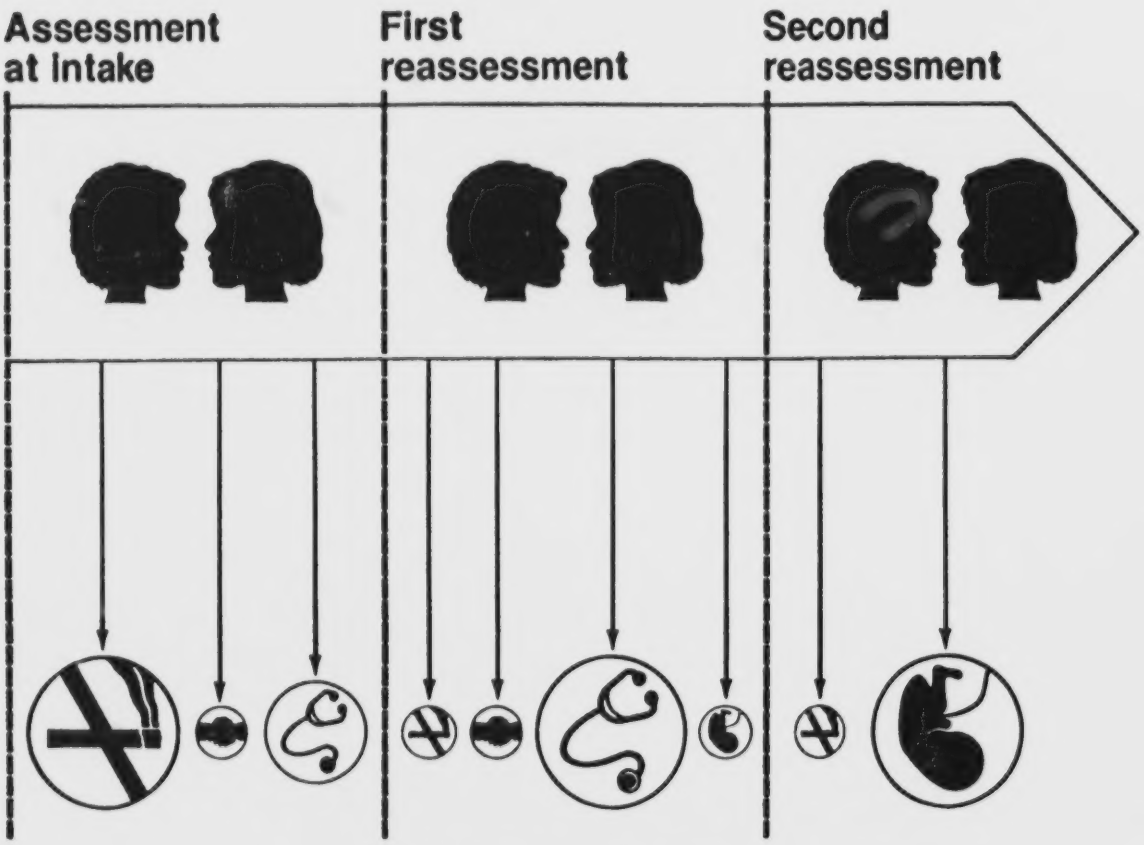
A wide array of risk-reduction services are offered to meet a variety of individual needs.

What Better Babies staff help participants to do.

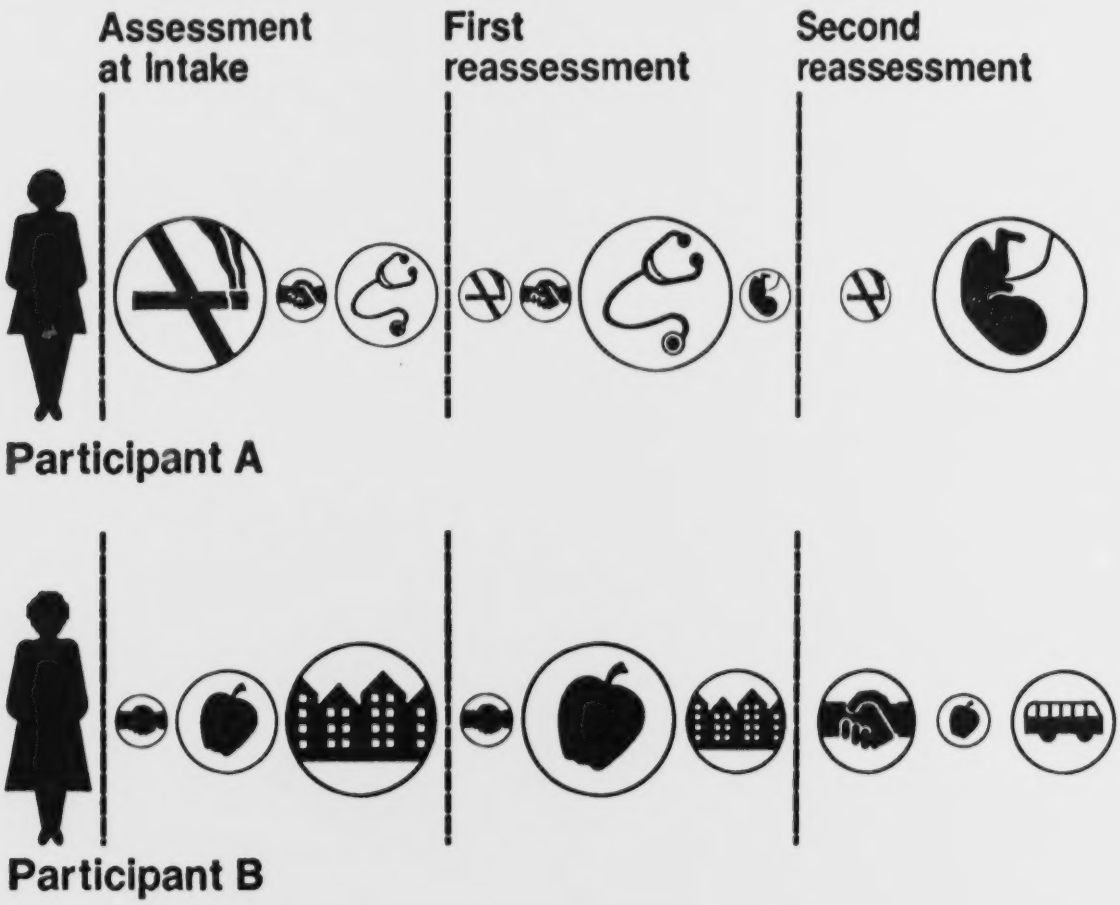
Services are provided according to needs; participants and staff reassess needs each month.



The type and amount of services are tailored to meet a participant's changing needs over time.



Individual services vary person to person and month to month, based on needs.



(This actual form is 11 x 17 inches)

Records of Needs and Plans

Name _____

ID# [ ][ ][ ][ ] - [ ][ ] - [ ][ ] - [ ][ ] - [ ]

Birthdate [ ][ ] - [ ][ ] - [ ][ ]
mo. da. yr.

	Original Plan	Update Number 1	Update Number 2	Update Number 3	Update Number 4	Update Number 5
	Date _____ SC: [ ][ ] - [ ][ ] OK by: _____	Date [ ][ ] - [ ][ ] - [ ][ ] SC: [ ][ ] - [ ][ ][ ] OK by: _____	Date: [ ][ ] - [ ][ ] - [ ][ ] SC: [ ][ ] - [ ][ ][ ] OK by _____	Date: [ ][ ] - [ ][ ] - [ ][ ] SC: [ ][ ] - [ ][ ][ ] OK by _____	Date: [ ][ ] - [ ][ ] - [ ][ ] SC: [ ][ ] - [ ][ ][ ] OK by _____	Date: [ ][ ] - [ ][ ] - [ ][ ] SC: [ ][ ] - [ ][ ][ ] OK by _____
	Needs? No Yes	Intervention applied? No Yes Still a problem? No Yes New need on this update?	Intervention applied? No Yes Still a problem? No Yes New need on this update?	Intervention applied? No Yes Still a problem? No Yes New need on this update?	Intervention applied? No Yes Still a problem? No Yes New need on this update?	Intervention applied? No Yes Still a problem? No Yes New need on this update?
Medical assess						
link w/new prenatal care	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
link w/mental health serv	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
reinforce medical advice	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
medical problem (specify) _____	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Other (specify) _____	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Food assess						
WIC	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
CSFP	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
food stamps	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
give food/refer to food source	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Entitlement assess						
Medicaid	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
AFDC	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
other (specify) _____	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Housing-related advocacy for						
back rent owed	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
possible eviction by landlord	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
possible eviction by relative/friend	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
utility cutoff	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
no housing	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
no furniture	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
other (specify) _____	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Friendly support						
by service coordinator	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
by BBP center activities	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Personal health habit awareness/ modification						
smoking	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
alcohol	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
drug	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
weight gain	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Needs to reduce physical effort						
at work	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
at school	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
at home	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
traveling	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
when moving	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
other (specify) _____	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Other referrals						
For maternity clothes	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
For baby clothes	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
For day care services	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
For education	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
For employment	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Transportation assistance						
To/from prenatal care	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
To/from hospital	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Other (specify) _____	( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )	( ) ( ) ( ) ( ) ( )
Planned o.e. contact:	(Check one)	# actual contacts: ____ Plan to contact: ( ) (1-2x) ( ) (3-5x) ( ) (6x+)	# actual contacts: ____ Plan to contact: ( ) (1-2x) ( ) (3-5x) ( ) (6x+)	# actual contacts: ____ Plan to contact: ( ) (1-2x) ( ) (3-5x) ( ) (6x+)	# actual contacts: ____ Plan to contact: ( ) (1-2x) ( ) (3-5x) ( ) (6x+)	# actual contacts: ____ Plan to contact: ( ) (1-2x) ( ) (3-5x) ( ) (6x+)
light (1-2x month)	( )					
medium (3-5x month)	( )					
intense (6x or more a month)	( )					
Prematurity Education		No Yes	No Yes	No Yes	No Yes	No Yes
Attended 1st PT class		( ) ( )	( ) ( )	( ) ( )	( ) ( )	( ) ( )
Attended 2nd PT class		( ) ( )	( ) ( )	( ) ( )	( ) ( )	( ) ( )
can list 3 PTL danger signs		( ) ( )	( ) ( )	( ) ( )	( ) ( )	( ) ( )
can list 6 PTL warning signs		( ) ( )	( ) ( )	( ) ( )	( ) ( )	( ) ( )

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Name _____

ID# ___ - ___ - ___ - ___ - ___

Birthdate: ___ (mo.) - ___ (da.) - ___ (yr.)

Date form begun: ___ (mo.) - ___ (da.) - ___ (yr.)

Activity Form Number ___

✓ = received stipend or dropped in at BBP
Where Code: T = telephone call H = home visit S = at site A = agency visit W = at work X = other
What Code: L = Linkage C = class or film D = one-on-one discussion with Participant N = see narrative comments

Activity	Date of Activity (mo. - da.) Who:															
	Where	What	Where	What	Where	What	Where	What	Where	What	Where	What	Where	What	Where	What
1. Stipend payment																
2. Drop in at BBP																
3. Smoking																
4. Prematurity Aware																
5. Weight Gain																
6. Alcohol Awareness																
7. Drug Awareness																
8. Prenatal Care																
9. Prenatal Emergency																
10. Other Medical Care																
11. Transportation																
12. Medicaid																
13. AFDC																
14. Food																
15. Back Rent Owed																
16. Possible Eviction																
17. Utility Problem																
18. Needs Housing																
19. Needs Furniture																
20. Needs Clothes																
21. Employment																
22. Education																
23. Rest																
24. Daycare																
25. Family Problem																
26. Pediatric Care																
27. Family Planning																
28. Form Interview																
29. Friendly Support																
30. Other _____																

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Table 1

Reasons Why Women Contacted Were Not Enrolled
for 1987 and 1988

Reason	Year	
	1987 (%)	1988 (%)
Lost before enrolled	47 (19)	64 (17)
29+ weeks G.A.	27 (11)	36 (10)
Not in area	71 (28)	130 (35)
Never pregnant	77 (31)	86 (23)
Early fetal loss	7 (6)	22 (6)
Pregnant, not interested	15 (6)	21 (6)
Induced Abortion	8 (3)	17 (5)
TOTAL CONTACTS	587	753
TOTAL NOT ENROLLED	252 (100)	376 (100)
TOTAL ENROLLED**	359	369

*Number in parentheses represents a percent of the "TOTAL NOT ENROLLED" group.

**In 1987, 43% of all 1987 contacts were not enrolled. In 1988, 50% of all contacts were not enrolled.

Note: Total enrolled plus total not enrolled does not equal total ICF's because some participants enrolled in 1988, but Initial Contact was during 1987.

Table 2

Days Between First Contact With a Pregnant Woman and Her Enrollment in the Program

Days Between Contact and Enrollment	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0-7 Days	542	67.0	542	67.0
8-14 Days	106	13.1	648	80.1
15-21 Days	73	9.0	721	89.1
22-28 Days	33	4.1	754	93.2
29-40 Days	35	4.3	789	97.5
41 Days or More	20	2.5	809	100.0

Note: Preliminary data; has not been submitted to final edits.

Table 3

Gestational Age of Women at Enrollment

Gestational Age	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Less than 10 weeks	138	18.8	138	18.8
11-16 weeks	227	30.9	365	49.7
17-20 weeks	147	20.0	512	69.7
21-24 weeks	114	15.5	626	85.2
25-28 weeks	109	14.8	735	100.0

Note: Preliminary data; has not been submitted to final edits.

Table 4

Reported Use of Cigarettes, Alcohol, and Street Drugs Prior to and During Pregnancy for Enrolled Women at First Interview

	Risk Status			
	Used Before Pregnant		Used After Pregnant	
Risk Substance (n)	Percent	Frequency	Percent	Frequency
Cigarettes (838)[1]	30.2	253	23.7	199
Alcohol (607)	31.6	192	8.9	54
Street Drugs (496)[2]	27.0	134	2.8	14

[1]About 42% of women report smoking at some time during their lives. Percentage is number of women who stated they smoked 1 or more per day in the last year, in either the before or after pregnant category, of total group.

[2]Answered yes to whether they had smoked anything other than tobacco in the last 2 years. Of 126 women 14 stated they still used this drug after becoming pregnant.

Note: Preliminary data; has not been submitted to final edits.